State of New Jersey
Department of Labor
DIVISION OF WORKERS' COMPENSATION

WC-170 (10-93)

ANSWERING STATEMENT TO MOTION FOR TEMPORARY AND MEDICAL BENEFITS (N.J.A.C. 12:235-5.2(e))

C.P. NO. _____

D.O. _____

PETITIONER

SOCIAL SECURITY NUMBER:

NAME:

COUNTY OF RESIDENCE:
ADDRESS:

ATTORNEY FOR RESPONDENT

FEDERAL EMPLOYER'S IDENTIFICATION NUMBER:
(If none, insert Social Security No.)

NAME:

ADDRESS:

TELEPHONE: (Area Code)

VS

RESPONDENT

NAME:

COUNTY OF RESIDENCE:
ADDRESS:

INSURANCE CARRIER

NAME: (Indicate If Not Covered or If Self-Insured):

CLAIM FILE NO.:
ADDRESS:

RESPONDENT, in answer to Petitioner's Notice of Motion for Temporary and Medical Benefits, respectfully states:

☐ That Petitioner is entitled to no Temporary Disability Benefits. (State medical, factual and legal reasons):

☐ That Petitioner is only entitled to Temporary Disability Benefits for the following period:

_____ to _____, or _____ weeks at $ _____ per week, (paid) (unpaid)

(State medical, factual and legal reasons):

☐ That Petitioner is not entitled to the medical treatment and payment thereof. (State medical, factual and legal reasons and attach pertinent reports, affidavits or certification):

Dated: _____

_____
ATTORNEY FOR RESPONDENT